



## Illinois Medical Cannabis Pilot Program Waiver for Increasing the Adequate Supply of Medical Cannabis For a Registered Debilitating Patient

### INSTRUCTIONS

Type or print clearly and answer all of the questions. **This waiver recommendation does not constitute a prescription for medical cannabis.**

**THIS MUST BE MAILED BY THE PHYSICIAN – DO NOT GIVE TO THE PATIENT**

**Mail this form, along with a check from the patient for \$25.00 (payable to Illinois Department of Public Health), to:**

Illinois Department of Public Health  
Division of Medical Cannabis  
535 West Jefferson Street  
Springfield, Illinois 62761-0001

### QUALIFYING PATIENT INFORMATION

First Name		Middle Name		Last Name	
Home Address					
Apartment or Suite #	City		State IL	ZIP Code	
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Qualifying Patient Registry Identification Number QP.		Qualifying Debilitating Condition			

### PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

First Name		Middle Name		Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)					
Suite #	City		State IL	ZIP Code	
Office Telephone Number (###-###-####)		E-mail Address			
Illinois Physician License Number			Illinois Controlled Substances License Number		
Length of time patient has been under your care (years/months)			Date of in-person medical examination relating to this waiver (mm/dd/yyyy)		

